THE JOURNAL OF SCHOOL HEALTH

Vol. XXIX No. 5

MAY
1959

— ANNUAL MEETING —
AMERICAN SCHOOL HEALTH ASSOCIATION
ATLANTIC CITY OCT. 18-23, 1959
HEADQUARTERS — CLARIDGE HOTEL

PUBLISHED BY
THE AMERICAN SCHOOL HEALTH ASSOCIATION

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THE JOURNAL OF SCHOOL HEALTH
THE AMERICAN SCHOOL HEALTH ASSOCIATION
Chicago, Ill.

Published monthly, except July and August, at Buffalo, N. Y.

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Membership dues, $4.00 including Journal;
Single Copies 50c, send payment with order

Address communications concerning publications

To THE EDITOR, The Journal of School Health
344 E. Quincy Street, Riverside, Illinois

Copyright, May, 1959

The American School Health Association

Entered as second-class matter at the Post Office at Buffalo, N. Y.
October 5, 1937

The Journal of School Health

is printed by

RAUCH & STOECKL PRINTING CO., INC.

120-130 ELMWOOD AVE., BUFFALO, N. Y. (near Allen)

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

Vol. XXIX MAY, 1959 No. 5

REPORT OF THE COMMITTEE FOR HEARING CONSERVATION OF THE SCHOOL HEALTH SECTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION AND THE AMERICAN SCHOOL HEALTH ASSOCIATION

INTRODUCTION

In 1954 a Committee for Hearing Conservation was appointed by the School Health Section of the American Public Health Association. The first year and a half was spent studying the problem in a general way. There was found a widespread expression of need for standardization of testing methods, criteria and educational opportunities. As a result, three and a half years ago the committee decided to make a comprehensive national study of testing programs used to detect hearing losses in school children and also the special provisions that are made educationally for those children. No survey had been made on the subject since that of Dr. Warren H. Gardner in 1947-48, according to the American Hearing Society. [1, 2]

A questionnaire of twenty-five items with subdivisions totaling forty-four separate items was then developed. Included were items on school population; equipment owned; grades tested annually; service or personnel testing; number of children tested, number failed and criteria used for failure when using phono-audiometer, group pure tone or individual pure tone sweep tests; criteria used when notifying the parent of a hearing loss; number of children with a hearing loss, also these classified by decibel losses; number receiving lip reading, auditory and educational training and criteria used in determining such need; number wearing own hearing aids and sources of free aids. An effort was also made to obtain the terminal incidence of hearing loss by requesting data on retests and medical care after defects were reported.* The questionnaire was used on selected groups in developing its final form.

Members of the committee included specialists in otology, in education and in school health services and they have represented the country geographically, from Texas, California, Colorado, Wisconsin, Michigan and New York. As the project progressed, interest in it led this past year to joint sponsorship by the American School Health Association and the American Public Health Association.

*A copy of the questionnaire is attached to this report (appendix B)

PROCEDURE

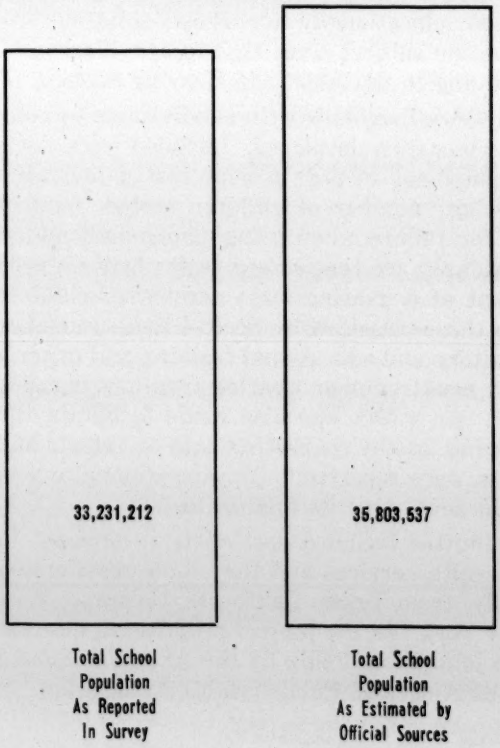
The questionnaire was sent in 1956-57 at the state level to all directors of hearing conservation of the State Departments of Education or Health. At the local level where a program of conservation of hearing was known to be a part of the school health services, questionnaires were sent to superintendents of schools, hearing consultants, school physicians, school nurses or health officers of local departments. In addition, questionnaires were sent to communities with a school population of 1000 or more, and to lists of suggested school personnel as provided by several state departments. On the local level a total of 2206 were distributed, and 1437 were returned.

RESULTS

Tabulations of the returns indicate the following results. Chart 1 represents 33,231,212 children on state level reports, or 92 per

Chart 1

Comparison of total school population as reported in survey and school population as estimated by official sources.


33,231,212
35,803,537
Total School Population As Reported In Survey
Total School Population As Estimated by Official Sources

cent of the 35,803,537 total school population as reported by the Commissioner of Education etc. [3, 4] All forty-eight states replied on the state level as well as the local level. Some states could give details of their programs and others reported that they had no state level programs.

Chart 2 shows a school population of 11,019,504 on the local level reports from individual communities or school systems, and the total number of children tested 3,454,343 or 31 per cent.

Chart 2

Comparison of school population with number tested.

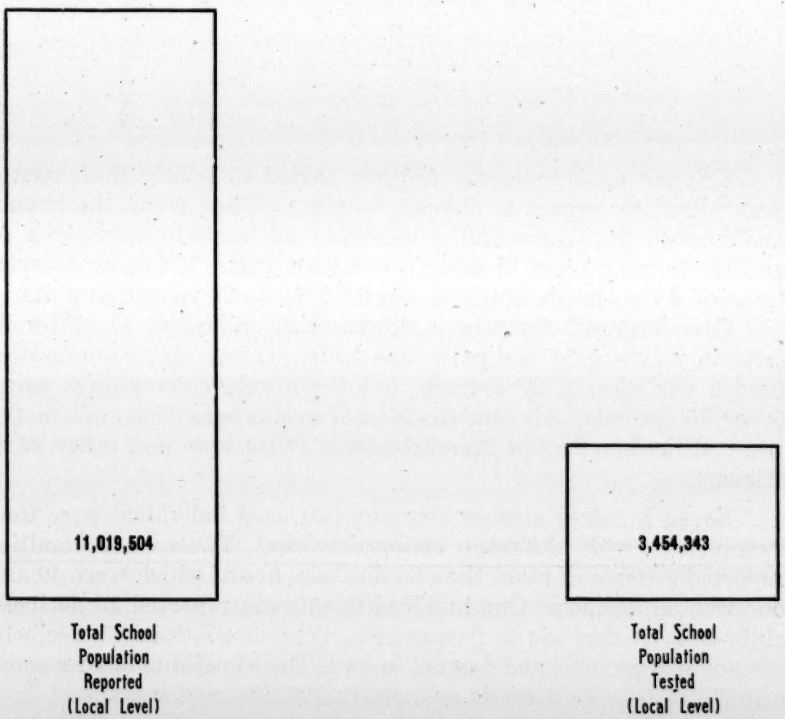


Table 1 indicates the number of audiometers owned or borrowed. Totals are 441 phono and 2,541 pure tone. The increasing use of pure tone equipment is exhibited in Tables 5 and 6. Several states reported that although they owned phono-audiometers they were not using them. Reports from thirty communities indicated they were using a variation of the watch tick, coin click or whisper test.

The question on the year when hearing tests were last made was answered as of 1956-57 when the form was distributed. Table

2 shows that although the large majority reported on either their preceding year's testing or their current program, there were a considerable number who had done no testing for two or three years, with some none or not known.

TABLE 1 — EQUIPMENT USED IN TESTING

Audiometers	Owned	Borrowed	Total
Phono	384	57	441
Pure Tone	2,325	216	2,541

TABLE 2 — YEAR LAST TESTED AS REPORTED IN 1956-1957

Year	Number of Communities
1956-57	363
1955-56	885
1954-55	124
1953-54	17
1952-53	5
1951-52	1
1950-51	2
NONE	2
NOT KNOWN	

Criteria used to report failures varied so widely that even a generalized statement is difficult to make. When using the phono-audiometer, 164 communities reported at least 10 variations of criteria ranging from 13 using 6 sensation units, 124 using 6 variations of 9 sensations units, through 12, 15 to 24 sensation units.

One hundred forty-two communities indicated 11 different criteria values in group pure tone tests. Thirty-nine communities used a variation of 20 decibels, but there were communities using 50 or 55 decibels. All combinations of group pure tone audiometry were utilized including Massachusetts, Pulse tone and other variations.

Seven hundred sixteen communities used individual pure tone sweep test with different criteria values. Twelve communities reported criteria of more than 30 decibels, five of which were 40 and one was 50 decibels. One hundred twenty-six reported 15 decibels, sixty-five 15 decibels 2 frequencies, fifty more than 15 decibels, fifty-one 20 decibels and five not known. The remaining 394 reported criteria of 6 to 40 decibels or more in 109 different ways.

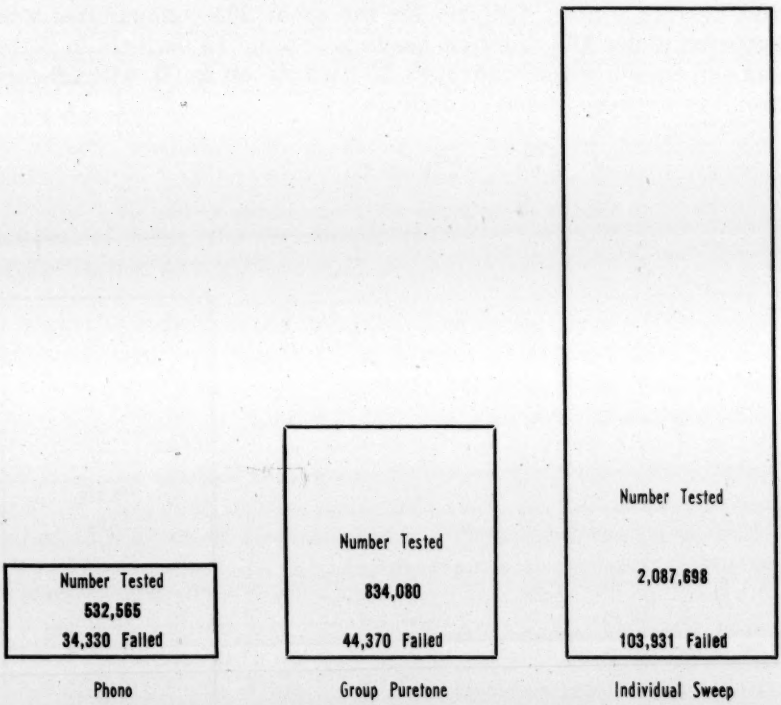
In general, phono, group pure tone and sweep test failures were given individual pure tone tests. The 866 communities giving individual pure tone tests to failures utilized 255 different combinations of the following general criteria with their many variations.

10	communities reported	40 db.
6		35 db.
37		30 db.
36		25 db.
307		20 db.
252		15 db.

Percentages, frequencies, recommendation of the American Academy of Ophthalmology and Otolaryngology, abnormal audiograms and local or state otologist's recommendations were also listed as criteria.

Chart 3

Children tested and failed and equipment used.



Criteria used in reporting to the parent when a hearing loss was detected were found to be extremely varied both in number and kind. One thousand one hundred thirty-six communities reported these criteria with their many variations.

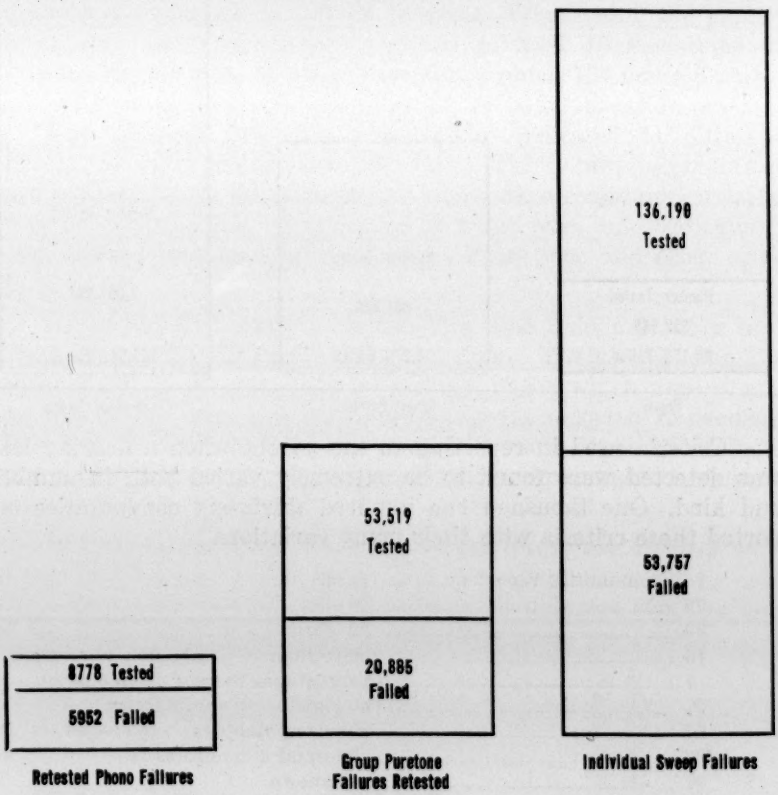
85 communities reported	15 db.
78	20 db.
30	30 db.
16	more than 30 db., 35 db., 40 or more
7	percentages varying from 9 to 30
27	otologist's recommendation
65	abnormal findings
228	abnormal audiograms
43	not known

In addition to these, other criteria reported were "teacher judgment", "RN thinks hearing faulty", "if severe handicapping loss", "inability to receive instruction in class", "suspected abnormality", and "failure with stop watch, spoken or whispered voice".

Lip reading instruction was provided by 496 communities for 11,292 children. One hundred ninety-three communities reported use of one of the following four criteria: recommendation of 1. speech therapist; 2. physician; 3. otologist; or 4. university speech and hearing center. Criteria for the other 303 communities were reported under 168 different headings, from "15 decibels in better ear and speech defect", through 25 decibels, on to 60, with 20 communities between 35 and 60 decibels.

Chart 4

Number of children retested with individual puretone and failed with individual puretone.



Three hundred sixty-five communities reported auditory training for 8,592 children. Criteria used most often included "otologist's recommendation" from 68 communities, "physician's referral" from 34 communities, and "hearing evaluation" from 12 communities. The remaining 251 communities reported under 129 criteria headings ranging from 15 to 55 decibels, and others as "need plus available time", "poor speech", "audiometric test", "profound hearing loss" or "recommendation of professional personnel".

Analysis of the data reveals no uniform criterion employed in interpretation of the tests. Many of the returns indicated an inability to interpret the results of the testing although reasonable criteria do exist for detection and selection of the children. Among the criteria available are those of the American Academy of Ophthalmology and Otolaryngology, the American Public Health Association and the American Medical Association. In spite of the existence of these, the data suggests an imperative need for the standardization of a uniform and pragmatic criterion.

Chart 3 indicates the number of children tested, failed and equipment used, and Chart 4 the number of failures retested by individual pure tone. The difference between those failing the group pure tone and the number retested with individual pure tone was equated, making a projection of the number tested to be 1,006,702. The number failing was 53,519, with a 5 per cent failure. The same procedure in testing by individual pure tone sweep test resulted in a figure of 2,746,044 tested. That figure compared with the number of failures of 136,190 also results in approximately a 5 per cent failure. The results show approximately 39 per cent of the 5 per cent failures had true hearing losses, in both group pure tone and individual pure tone sweep test failures on retesting with individual pure tone. Since 11,019,504 would be considered a fair sample of the total school population of 35,803,537, 5 per cent or 1,790,176 would be expected to fail the group tests, and 39 per cent of those or 698,168 children in our schools in the United States would be expected to have true hearing losses. Since criteria are so diversified and frequently too high, many children with true hearing losses are not reported. Therefore, the actual figures might be substantially greater.

Chart 5 reveals 17,527 of the 80,159 children with known hearing losses have no classification reported of their hearing losses.

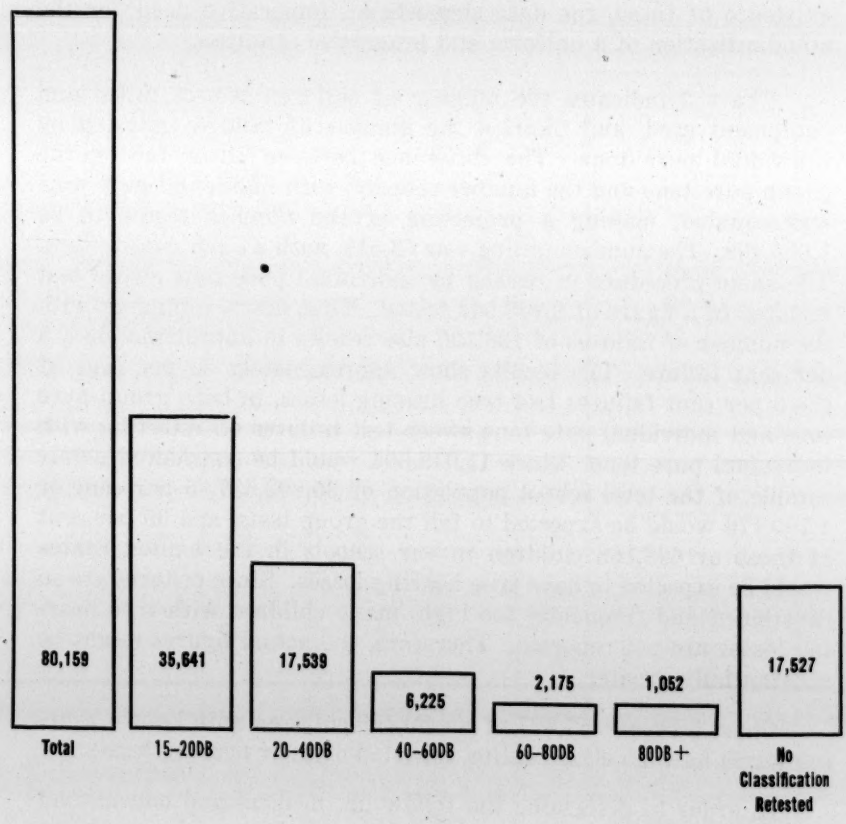
In order to determine the follow up, medical and educational provisions, Chart 6 gives the comparison of the total known hear-

ing losses with the number of children who have training and/or hearing aids. Of 80,159 children known to have losses, 4703 own hearing aids, 11,292 receive lip reading, 8,592 receive auditory training and 3052 receive educational training. The data suggests that only 15 to 20 per cent of children with known hearing losses are receiving any kind of educational help because of their hearing loss. It indicates that many children are not receiving help and are not provided with an opportunity for optimum learning and adjustment.

The majority of the 1331 communities reporting when a parent is notified of a child's hearing loss indicated they did so immediately after the hearing test is made.*

Chart 5

Known hearing losses as reported.



*See appendix A.

Chart 6

Comparison of total reported known hearing losses with number of children who have training and/or hearing aids.

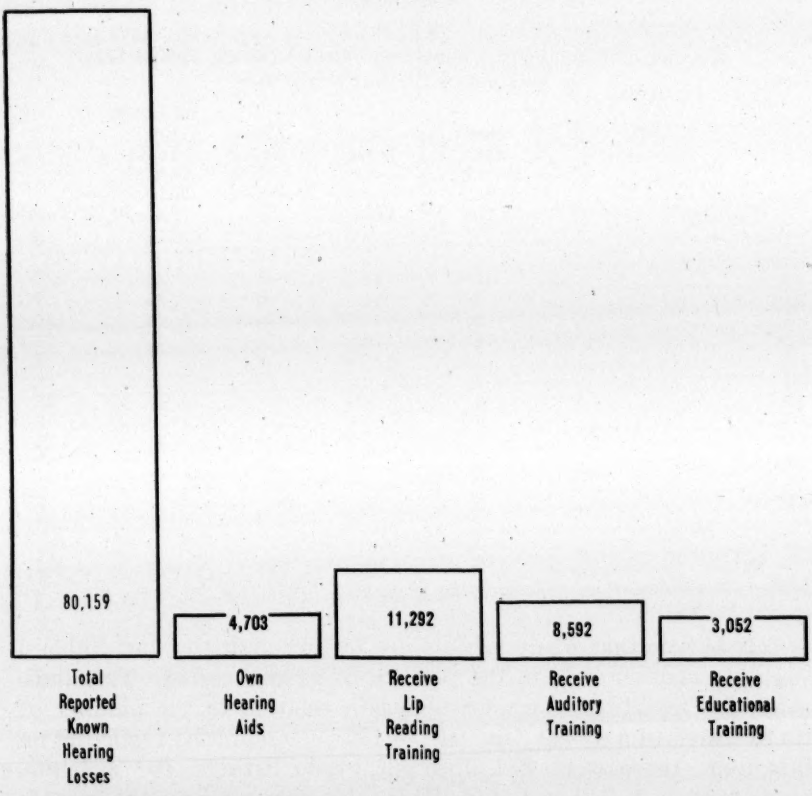


Table 3 in some measure indicates the pattern of grades tested annually in the entire country. Although in the table there are 1070 of the 1362 communities reporting that their children are tested at least four times in a school life, there are 39 who test once in a school life, and of those, 7 do not begin testing until at least the seventh grade. Thirty-eight give two tests in a school life with 2 beginning testing at the seventh grade. One hundred fifty-seven give three tests in a school life with 13 beginning testing at or after the seventh grade. This kind of testing would appear inconsistent with the desirable medical, educational and mental hygiene principles. Many of the hearing losses due to otitis media etc. found in

children tested for the first time in the upper grades might have been prevented it testing, followed by proper medical care, had been carried out in the lower grades. Furthermore, a good deal of frustration and other emotional disturbances mar the normal growth and development of such children.

TABLE 3
Number of Communities Reporting Testing During School Life in Relation to Earliest Grade Test

Start Testing	One Test During School Life	Two Tests During School Life	Three Tests During School Life	At Least Four Tests During School Life	Totals
Preschool	.....	.....	1	4	5
Kindergarten	.....	2	5	516	523
1st	13	12	40	264	329
2nd	3	13	27	34	77
3rd	9	7	59	61	136
4th	5	2	6	12	25
5th	1	.....	1	2	4
6th	1	.....	1	1	3
7th	3	2	6	25	36
8th	1	.....	.....	4	5
9th	1	.....	1	11	13
10th	1	.....	6	.....	7
11th	.....	.....	.....	.....	.....
12th	1	.....	.....	.....	1
Not indicated	.....	.....	4	136	140
Totals	39	38	157	1,070	1,304

Note: 58 communities reported "no program" "referrals or new only" "not known".

It is true that many schools are testing annually, but Table 4 suggests another side to the pattern of grades tested. This indicates the variation of grades tested in relation to the number of times tested in a school life. Of the 1362 communities reporting on this item, there were 356 different grade listings, for example, kindergarten, 1, 2, 6 or 1, 4, 8. This table demonstrates the exceedingly large spread of the grades tested. Using the base as the grade when testing is started, it is seen that 5 communities start testing at preschool, 57 with kindergarten, 130 with first grade, 36 with second, 57 with third, 20 with fourth, 4 with fifth, 3 with sixth, 7 with seventh, 2 with eighth, 3 with ninth and 2 with tenth grade. One community begins the program at the twelfth grade, which is too late to give any real educational assistance to the hearing handicapped child.

Research clearly indicates that the best preventive work is done when hearing losses are detected early and referred for medical help. It appears logical that the earlier the test is made, the

greater is the probability that hearing losses may be reversible, since by the time the child reaches seventh grade the hearing loss may be irreversible. Where loss is irreversible, early provision of educational differentials is conducive to and promotes better adjustment and learning.

TABLE 4

Of Those Who Report Testing 1, 2, 3 or at Least 4 Times in a School Life, This Shows Variations of Ranges of Grades Tested, When Starting Testing at Each Grade Level.

Start Testing	One Test During School Life	Two Tests During School Life	Three Tests During School Life	At Least Four Tests During School Life	Totals
Preschool	.....	.....	1	4	5
Kindergarten	.....	2	5	50	57
1st	7	9	24	90	130
2nd	2	6	8	20	36
3rd	3	5	10	39	57
4th	3	2	6	9	20
5th	1	.....	1	2	4
6th	1	.....	1	1	3
7th	3	1	1	2	7
8th	1	.....	.....	1	2
9th	1	.....	1	1	3
10th	1	.....	1	.....	2
11th	.....	.....	.....	.....	.....
12th	1	.....	.....	.....	1
Not indicated	.....	.....	4	12	16
Totals	24	25	63	231	343

Note: 13 additional variations were reported with no indication of number of times in school life.

In response to the questions on terminal incidence, the answers are ambiguous, inconsistent and incomplete. On the basis of the returns, no satisfactory analysis can be projected.*

The direction of the hearing conservation program on the local level comes from several types of services or personnel. Nurses, school physicians, speech and hearing consultants, speech and hearing therapists or combinations of these account for a large number of the 1342 communities reporting. State departments of education, boards of education, state or local health departments or variations of these contribute another large segment of directors. There are many others entrusted with this program, including a director of physical education, vocational rehabilitation, hospital league and private organizations.

*See appendix A.

Personnel actually administering hearing tests represented professionally trained individuals, speech and hearing therapists, nurses, audiologists and especially trained teachers or teams under the direction of these. Nevertheless, 37 of the communities utilized volunteers, including a secretary, a service club and a commercial salesman.

Overall direction of programs falls under one of three categories, namely, (1) state directed, with state supervision and state personnel conducting the program on the local level; (2) state directed but with local autonomy; (3) local administration only. In the majority of states, procedures are administered on the local level. While most states participate, their share is consistent with local resources, funds and needs. A number of states make audiometers available and provide a variety of consultive services.

Examination of the state laws on conservation of hearing reveals a wide variation in scope and intent. Some have comprehensive mandatory provisions, others have very limited coverage while still others have permissive clauses only. On the other hand, some states have no law pertaining to conservation of hearing in children. Laws range from those which provide only for a school for the deaf to those covering complete programs including annual hearing tests for all children, medical and surgical care, hearing aids, lip reading and other educational training for children in need of such services. It would appear logical that some uniformity in the basic philosophy of the principles involved in the laws might be good for the general welfare.

CONCLUSIONS

Conclusions drawn from this study include the following:

1. Analysis of data from questionnaire returns unequivocally reveals no uniform program for detection of hearing losses for the entire country. The program varies from very satisfactory in a few areas to no program at all in some other areas.
2. The data also shows that no uniform criteria for failure exists. The criteria range from 10 to 55 decibels. This lack of uniform criteria would suggest that many children are not discovered at a time when medical help might prove crucial in reversing the hearing loss.
3. Examination and analysis of the materials further reflects the absence of an organized program for referral and follow up purposes. On the basis of the absence of such a program, many children may not be receiving the proper educational differentials necessary for growth and development consistent with child developmental principles and mental hygiene.

4. The investigation also clearly reflected limitations on record keeping not consistent with adequate discovery, diagnosis and medical and educational treatment.
5. No uniform standard operating procedure exists for provision of the necessary medical and educational aid.
6. The study also clearly pointed out the absence and limitation of guidance programs for localities.

RECOMMENDATIONS

1. On the basis of the returns, it would appear advisable to set up procedures and agencies for administration and coordination of proper policies which would facilitate and expedite early detection, proper medical referrals and provision of the necessary educational differentials consistent with individual needs.
2. In accordance with good administrative policies, each state might provide a program of study to collect data and evaluate the needs of individuals, which should help in the determination of an optimum conservation of hearing program. The state's leadership should be autonomous although it might solicit the aid of federal funds. Such leadership would include a research and evaluation committee whose findings could then be coordinated at the local, state and national levels.
3. Definite and clear cut policies concerning testing personnel should evolve from such a study. Such policies might include training at the university level supplemented with in-service training.
4. A national committee with adequate representation from each area might be set up to study, analyze and evaluate the present laws with the express purpose of recommending legislation on a nationwide basis.

Respectfully submitted,

C. ADELE BROWN, M.D.,
Chairman.

APPENDIX A

a. The numbers of each of the three different time schedules of reporting when a parent is notified of a child's hearing loss follows:

After school physician's examination	70
After school otologist's examination	51
Immediately after hearing test is made	1210

b. Eight hundred and seven children were reported as recommended for schools for the deaf, and 4124 are enrolled. These figures are not truly representative, as they are only those children known by the local schools. They cannot, of course, include

those not under their care or those placed in schools for the deaf from the time of preschool age and therefore unknown to the schools. It is a subject not dealt with in the study except for these figures and the lack of local reporting prohibits further discussion. For further information on this population, see *Annals of the Deaf*.

c. The following is a summation of the replies on terminal incidence:

Failed 54-55 and failed again 55-56	17,433
Failed 54-55 retested 55-56	25,875
Failed 54-55 retested and failed 55-56 and received medical care since 54-55 reporting	14,999
Tonsils and adenoids in this group removed since 54-55 reporting	2,952
Failed 54-55 and normal test 55-56	8,829
Failed 54-55 retested and normal 55-56 and received medical care since 54-55 reporting	8,562
Tonsils and adenoids in this group removed since 54-55 reporting	2,969

d. The following are the major sources reported for borrowing equipment:

State Education Department
State and County Health Department
Other schools
Board of Cooperative Educational Services
Audiometrician's own equipment
County Health Association
County Vocational Board

e. The most frequently reported sources of free hearing aids and batteries are:

State Aid to Handicapped
Crippled Children's Society
State or local departments of Health
State or local departments of Education
League or Society for hard of hearing
State or local welfare departments
Service, charitable or civic organizations
Universities
Hospitals
Private individuals
Commercial companies

REFERENCES

1. American Hearing Society, Washington, D. C., Personal Communication, July, 1955.
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3. *Enrollment, Teachers and School Housing*, U. S. Department of Health, Education and Welfare, Office of Education, Circular No. 490, (1957) 4.
4. National Catholic Welfare Conference, Department of Education, Washington, D. C., Personal communication, February, 1958.

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APPENDIX B — QUESTIONNAIRE

THE COMMITTEE FOR HEARING CONSERVATION OF THE SCHOOL HEALTH SECTION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Date.....

Name of town (County District)..... State.....
Report made by..... Title.....
Street..... City..... Zone..... State.....

1. What is your total school population?.....
2. How many audiometers of each type do you own: (a) Phonograph Speech Audiometer..... (b) Pure Tone Audiometer.....
3. If you do not own an audiometer: (a) Do you borrow one?..... (b) If so, from whom?..... (c) State types.....
   (d) What service or person gives your audiometer tests?.....
4. What grades are tested each year?.....
5. In what school year were your hearing tests last made?.....
6. (a) If you used a Phonograph Speech Audiometer only, how many children were tested?..... (b) Number of failures.....
   (c) State criteria for failures: .....
7. (a) If you used a Group Pure Tone Test only, how many children were tested?..... (b) Number of failures..... (c) State criteria for failures: .....
8. (a) If you used an Individual Sweep Test only, how many children were tested?..... (b) Number of failures..... (c) State criteria for failures .....
9. (a) How many children who failed the Phonaudiometer test were retested with the individual Pure Tone Audiometer?..... (b) How many failed this individual test?..... (c) State criteria for failures .....
10. (a) How many children who failed the Group Pure Tone Tests were retested with the individual Pure Tone Audiometer?.....
    (b) How many failed this individual test?..... (c) State criteria for failures: .....
11. (a) How many children who failed the individual Pure Tone Sweep Test were retested with the individual Pure Tone Audiometer?.....
    (b) How many failed this individual test?..... (c) State criteria for failures .....
12. If you do not use an audiometer, how do you test hearing?.....
13. What criteria do you use for reporting a hearing loss to a parent?.....
14. Please check when the hearing loss is reported to the parents: (a) After examination by the school physician?..... (b) After examination by the school otologist?..... (c) Immediately after the hearing test is made?.....

15. (a) How many children in your schools have a hearing loss?.....
(b) How many fall into the following categories: A. 10-20 db.....
B. 20-40 db..... C. 40-60 db..... D. 60-80 db..... E. 80 or more db.....

16. (a) How many children were given lip reading instruction in the school year 1955-56? ..... (b) What are your criteria for selection of pupils for lip reading instruction?.....

17. (a) How many children are receiving auditory training?.....
(b) What are your criteria for selection of pupils for auditory training?

18. How many pupils wear their own individual hearing aids: (a) Pre-School age..... (b) Kindergarten through eighth grade.....
(c) High School.....

19. How many of these hearing aids were given free to the children?.....

20. What agency or organization gives: (a) Free hearing aids to children?

(b) Free batteries to children?.....

21. How many children are receiving educational tutoring in addition to lip reading and auditory training?..... (a) How many children were recommended for schools for the deaf in 1955-56?..... (b) How many children from your schools are now enrolled in schools for the deaf?.....

22. In order to determine the terminal incidence of hearing loss, will you please answer the following questions:
A. 1—How many children who had a reported hearing defect for the school year 1954-55 still failed and are included in the 1955-56 list of pupils with hearing defect?.....
2—How many children who had a reported hearing defect for the school year 1954-55 were retested in 1955-56?.....
3—How many of these received medical care since the hearing was reported in 1954-55?.....
4—How many had T&A after hearing was reported in the school year 1954-55?.....
B. 1—How many children who had a reported hearing defect for the school year 1954-55 gave a normal test in the 1955-56 school year?.....
2—How many of these children received medical care since the hearing was reported in 1954-55?.....
3—How many had T&A after hearing was reported in the school year 1954-55?.....

23. (a) Who directs your hearing conservation programs?.....

(b) Please outline special features and regulations applying to your programs. (If necessary, an extra sheet may be used).....

24. Please report any further information regarding your hearing conservation program which you feel is significant. .....

25. To whom should further correspondence regarding your hearing conservation program be addressed?
Name..... Title.....
Street..... City.....
Zone..... State.....

Will you please assist this committee by completing the above questionnaire as soon as possible and return it to C. Adele Brown, M.D., Chairman: 105 East 6th St., Oswego, New York. Even if you are unable to supply all of the information requested, please supply as much of it as you can. We shall greatly appreciate your cooperation.

Please record criteria in decibels or percentage loss in questions 6, 7, 8, 9, 10, 11, 13.

NEWS NOTES

Doctor Delbert Oberteuffer, President of the Association, has appointed Doctor Mary Spencer as official delegate of the American School Health Association to the fourth international meeting of the International Union for Health Education of the Public to be held at Dusseldorf, West Germany May 2-9. The following week she will observe the meetings of the technical sessions of the Public Health Education Section, World Health Organization at Geneva. She was elected a delegate-at-large representing individual members at the first annual meeting and Delegate Assembly of A.N.C.H.E.P. held in February at New York City.

* * * * *

REPORT OF THE TUBERCULOSIS COMMITTEE

Our National Tuberculosis Committee headed by J. A. Myers, M.D., consists of twelve of the leading physicians in the nation who are interested in tuberculosis control through the schools. They have ten sub-committees consisting of fifty-five physicians.

These sixty-seven physicians from all parts of the nation present quite an array of medical talent and medical resources. They are dedicated physicians who believe that the American School Health Association has a mission to perform in establishing an effective program of tuberculosis prevention through the schools where every child in the nation is reached.

In addition to this medical staff they are assisted by a score or more of health education and other specialists working in the field of tuberculosis.

This committee has been working consistently year in and year out for the past twenty-five years. Dr. Myers has not missed making a yearly report for the past quarter of a century.

This year's report with the papers read at our session held in connection with the 54th annual meeting of the National Tuberculosis Association are in our April 1959 Journal.

Extra copies of the Journal and extra copies of the April 1958 Journal containing last year's report and the papers of our session given in the 53rd annual meeting of the National Tuberculosis Association are available. The cost is fifty cents (50c) per journal.

—A. O. DeWeese, M.D.

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* * * * *

SCHOOL HEALTH SESSION TO PRECEDE ATLANTIC CITY A.M.A. MEETING

School health will be the subject of a meeting to be held at the Claridge Hotel, Atlantic City, Park Place and Boardwalk at 7:30 p.m., on June 7, 1959. Interested physicians will find it convenient to combine attendance at the school health sessions with the A.M.A. meeting which officially opens the next day.

The program, to feature discussion of "The Changing Role of the School Physician", "The Future of School Nursing" and "Trends in School Health Education" is open to school personnel as well as the medical profession. The American School Health Association is sponsoring the meeting in cooperation with the A.M.A. Department of Health Education.

Those attending this meeting who are not physicians may obtain guest tickets if they wish to view the exhibits or to attend any of the scientific sessions at the A.M.A. meeting.

* * * * *

REVIEWS

The Alive and Growing Teacher by Clark E. Moustakas (157 pages) Merrill Palmer School. Publ. Philosophical Library, New York.

An account of some of the problems of classroom teachers and principals and the experiences and conditions which form the basis for their philosophy based on respect, acceptance, and love as expressed through daily classroom living.—M. A. H.

INTERNATIONAL HEALTH A VALUABLE ADDITION to the UNIVERSITY CURRICULUM

ROBERT D. RUSSELL, Ed.D.

Stanford University

The need for an enlightened health education of the public is now an established fact. The term health education might be mistaken to imply only health instruction. This stage, however, lies behind us and health education, recognized as an essential component of every social welfare programme, must become an education for living.[1]

The above words formed part of the "message" by Professor Jacques Parisot to the International Journal of Health Education in its first issue; the idea it suggests to me is an interesting one: that education in health is essential to living — fully and vitally — in today's world. Further, health instruction in regard to elements of personal health is only a beginning — a base from which one can profit from education in what really constitutes health and ill-health in our total world community. Just as the United Nations has helped us (perhaps "forced" us) to look at our country as a part of a world community, so the work of the World Health Organization over the past twelve years has pointed up the need to see health as a vital factor in world affairs. Seeing it thusly we are struck by the great disparities in "physical, mental, and social well-being," — which is "health," by definition.[2]

Attempts to educate "the public" — or any specific publics — to a world-wide look at health have not been extensive in this country as yet; lectures or talks by individuals who have participated in some international venture have been more the rule than any systematic approach, i.e., a specific course. But with the tenth anniversary of the WHO came a flood of materials which, in various ways, evaluated the work of this decade of genuine international cooperation in health matters. In this context the author saw great possibilities for developing a university course of major significance. The opportunity was forthcoming; in the light of the experience of offering such a course I would offer some suggestions to those who might be likewise motivated.

1. A suggested rationale for the course would be: "the health conditions and health practices of a country or region — or cultural sub-group within either — are an integral part of that culture and

1 Parisot, Jacques, "Message," International Journal of Health Education, 1:2, January, 1958.

2 Constitution of the World Health Organization, Official Record of the World Health Organization, 2:100, 1947.

can only be understood as they are seen in the light of the values of that culture."

2. Three approaches should be utilized in parallel ways: (a) an exploration of geographical-cultural areas of the world, noting the health conditions and health practices found therein, (b) a consideration of the general relationship between health and various other aspects of a culture (i.e., health and national and international politics, health and climate—geography, health and social custom, and health and religious beliefs), and (c) an investigation of a disease or group of health conditions, noting where and why they occur as they do.

3. In order to effect the most profitable exploration of the approach lettered (a) above I would suggest the use of selected foreign students or faculty on the campus or visitors in the community. Selected on the bases of ability to communicate in English and general awareness of life in their native country, these guests can do much to establish "feeling" about their native customs and ways of living. Though some specific knowledge of health facts is desirable, many students or visitors do not possess this; given sufficient time for some preparation (and some encouragement), however, they can manage a creditable amount of self-health education.

4. The approach denoted as (b) can utilize various students in the course from the appropriate disciplines and/or selected faculty colleagues from political science, anthropology, geography, etc.

5. The third approach should utilize the complete range of teaching methods, including lecture-discussion, problem solving, self-tests, films, student reports, and, occasionally, a medical guest speaker (if some are available who have had personal experiences with a disease or health condition under study).

6. The text used should follow the general rationale of the course, and should impart "feeling" more assuredly than merely factual material. Just such a book is *Doctors to the World* by Murray Morgan. Two other sources which make a balanced triumvirate with Morgan are *Ten Steps Forward* by Calder and *Problems in Intercultural Health Programs* by Foster. Other readings of further assistance are listed in the bibliography.

7. With the tremendous selection of countries and cultural areas — and diseases and other conditions of ill-health — available, there is a temptation to "pack the course" and attempt to cover too much. Particularly if any substantial number of students have

had little or no previous work in health, it is important to effect some careful selections, freely admitting the necessity of sampling. Since the overall objective is a generalized one, its achievement is not at all contingent upon "covering all of the ground" but in covering that selected with skill, understanding, and discretion.

As a final statement I would note that before offering such a course again I would contact and talk with certain department heads and advisors in the university (particularly geography, anthropology, and international relations) and encourage them to steer their students to such a supplement to their major study. I feel that the course should be kept at a level from which the general university student, graduate or undergraduate, might profit with no previous work in health.

Increasingly, the university graduate of today and tomorrow will be a traveler in and a participant in some of the affairs of countries and regions outside of the U.S.; his success in international endeavors will have some direct relationship to a broad and varied understanding and appreciation of other ways of life — and to his ability to demonstrate these. With one of the university's major aims in general education centering in preparing students to be capable, alert, and informed citizens — of their country *and* of the world — the offering I have outlined could certainly be a major contribution by health education to this aim.

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SCHOOL HEALTH PREPARATION OF PROSPECTIVE TEACHERS IN NEW MEXICO — EVALUATION OF AN EXPERIMENT IN COOPERATION

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Health education preparation of prospective teachers has become a topic of world-wide interest. During the past year or so, several state conferences have been held to plan for the improvement of programs relating to this topic. One of the first states in this country to conduct such a conference on a state-wide basis was New Mexico. Since this was a pioneer effort, it was difficult to guess what factors might contribute to the successes or failures of the conference. Time has provided the opportunity to give a backward look, and to analyze some of these factors in addition to the conference results. In this article, an attempt has been made to summarize the findings and conclusions of this analysis.

In the Fall of 1957, New Mexico held its first Conference on Health Education for Prospective Teachers. The conference was sponsored by the New Mexico State Coordinating Committee on School Health. This Committee is comprised of special representatives from the state departments of education and public health. In addition, the Committee has consultant representatives from twenty-five various state health and education agencies, organizations, and institutions. Personal invitations to the conference were sent to the college deans and heads of departments of health, physical education and recreation of each teacher education institution; representative teachers and school administrators; and the state medical and dental associations.

Specific objectives of the Conference were:

1. to reach a common understanding concerning the necessary functions and responsibilities of the classroom teacher in the total school health program, and
2. to determine how teacher education institutions could best prepare teachers to carry out these functions and responsibilities both adequately and effectively.

During its two-day session, the Conference agreed that the general education of every prospective teacher should include experiences which enable him to understand and to protect his own health; to develop a body of basic information essential to an understanding of the health of individuals and groups, and to recognize the need for continuously increasing his knowledge.

Using as discussion bases the recommendations for health functions and health preparation of teachers outlined by the National Conference on College Health,[1] the Conference determined similar recommendations for New Mexico. Efforts to achieve the second Conference objective were centered on another series of recommendations aimed at increasing graduation and certification requirements in regard to school health for all prospective teachers in New Mexico. The complete conference report[2] is available on request.

Conference Recommendations — In July, 1958, the Coordinating Committee was fortunate to obtain the temporary services of a graduate public health education student from the University of California who had been assigned for field training to the New Mexico Tuberculosis Association. One academic year had elapsed since the Conference and the Committee was anxious to determine the current status of each recommendation among the various teacher education institutions involved. With the help of the graduate student, the Committee was able to complete a personal interview survey in each college and university. The following is a summary of Conference recommendations, including the results of the subsequent survey:

1. The Conference recommended that each college and university require of all prospective teachers a three semester hour, upper division level, professional course in school health. It was recommended further that the general content and outline of the course be developed by the New Mexico State Coordinating Committee on School Health in cooperation with appropriate representatives from each of the state's teacher education institutions.

   The school health course outline was subsequently developed as recommended, and the 1958 survey revealed that:

   a. all seven institutions now offer a course or courses in the subject area of school health. Five of the seven institutions have adopted and are presently using the newly developed school health course outline. Of the two remaining institutions, one has the outline under consideration for approval, and is presently offering two school health courses that cover essentially the same material given in the new course out-

1 National Conference on College Health Education, "Health Education for Prospective Teachers", Washington: American Association for Health, Physical Education and Recreation, 1956.

2 New Mexico State Coordinating Committee on School Health, "Preparing Prospective Teachers in School Health", a report of the 1957 New Mexico Conference on Health Education for Prospective Teachers, Santa Fe: New Mexico Department of Public Health and State Department of Public Instruction, 1957.

line. (With the latter factor in mind, this institution's efforts thus far have been directed mainly toward increasing graduation requirements in the area of personal and community health). The other institution has chosen temporarily to adapt major portions of the new course outline to fit their existing course in school health.

b. four of the seven institutions now require the new school health course for all prospective teachers. Of the remaining three institutions, one now requires a school health course for all physical education majors, and is aiming at increasing the requirement to include all prospective teachers. Another institution presently requires their school health course for elementary education majors only, and the third offers it as an elective course.

c. all seven institutions reported that their school health course or courses are now offered at the upper division level.

d. six of the seven institutions stated that their school health course was offered for three semester (five quarter) hours of credit. The remaining institution offered their course for two semester hours "for the present."

2. The Conference had requested that the Coordinating Committee present to the New Mexico Teacher Education Professional Standards Commission, and subsequently to the State Board of Education, a recommendation to the effect that a course in school health be a specific certification requirement for all New Mexico elementary and secondary teachers. The Teacher Education Professional Standards Commission, among other things, serves in an advisory capacity to the State Board of Education on all matters concerning teacher certification. This commission now has the Conference's recommendation under consideration.

3. The Conference recommended that each college and university require a basic background course in personal and community health for all its freshmen students. When the new school health course outline was developed, the planning group also recommended that a personal and community health course be considered as a prerequisite to the school health course. Survey findings indicated that:

a. five of the seven institutions are currently offering a course in personal and community health. Of the remaining two institutions, one anticipates offering such a course in 1959. The other institution is planning, initially, to require for all

students a course in personal hygiene, and to consider addition of community hygiene to the course at a later date.

b. one institution requires the course for all physical education majors and is working toward making it a requirement for all prospective teachers. One institution requires the course for all prospective teachers. One institution requires the course for all students. Two institutions require personal hygiene for all physical education majors, and one of these institutions also requires community hygiene for all education majors. Both of these two institutions are working toward a requirement for all prospective teachers. One institution offers the course as an elective only.

4. The Conference recommended that the establishment of student-faculty health councils be considered by each college and university. Survey findings revealed that:

   a. four of the seven institutions have some form of campus health council, but these are generally limited to being a part of the schools' student council activities. These institutions feel that this arrangement is satisfactory for the present.

   b. the three remaining institutions have made various administrative provisions for taking care of their students' health problems.

5. The Conference recommended that each teacher education institution examine its curriculum for the purpose of determining how it could integrate additional school health experiences into related courses within its curriculum and related co-curricular activities. Survey findings showed that:

   a. two of the seven institutions have course syllabi and are in the process of examining related courses for the suggested integration opportunities.

   b. four institutions indicated that a formal attempt to fulfill this recommendation is not presently possible, because they have no syllabi of their courses.

   c. one institution stated that, at present, they were satisfied with the health content of related courses.

6. Other survey findings related to Conference discussions indicated that all seven institutions require a physical examination of each new student, and one institution requires all faculty members to have a physical examination. In addition, one institution is presently planning a program of screening students

for entrance to their professional teaching program. This will include, in addition to freshman entrance examinations, some form of psychological screening and some form of faculty screening of students.

7. The Conference was in agreement that the 1957 meeting should be considered only as the first of a series of such meetings, and that after a year or two of work on recommendations a follow-up conference should be held.

Program Coordination — In 1956, a significant project was initiated by the New Mexico State Coordinating Committee on School Health. It involved the establishment of basic criteria for a school health program which could be recommended for all elementary schools in the State. The results of this project, in turn, became the basis for the development of a "School Health Evaluation Guide for Elementary Schools".[3] It was decided that a similar guide for secondary schools would be attempted at a later date. In addition to its worth as an evaluation instrument, the guide was intended to serve as a source of in-service education. These guides were distributed to every elementary school administrator in the state, and an intensive promotional campaign was conducted to encourage its use.

In an attempt to coordinate the combined evaluation and in-service education project on the local level with the project concerning health education for prospective teachers, the Coordinating Committee completed a "School Health Manual for Elementary and Secondary Schools".[4] This manual was distributed without charge to all in-service school personnel in the State, as well as to all state and local health department personnel. A promotional campaign is also being conducted in which the guide is recommended for use as a basis for local school health program planning and discussion. In addition, arrangements are being made to require the same guide as a supplementary text in the school health courses offered in each teacher education institution.

Success Factors — and a Pitfall — During the initial stages of planning the Conference on Health Education for Prospective Teachers, the Coordinating Committee was fortunate to obtain the services of a national consultant, Dr. Bernice Moss, U. S. Public Health Service. Dr. Moss had been chairman for a national conference on health education for prospective teachers in 1956, and

3 New Mexico State Coordinating Committee on School Health, "School Health Evaluation Guide for Elementary Schools", Santa Fe: New Mexico Department of Public Health and State Department of Public Instruction, 1956.

4 New Mexico State Coordinating Committee on School Health, "New Mexico School Health Manual for Elementary and Secondary Schools", Santa Fe: New Mexico Department of Public Health and State Department of Public Instruction, 1958.

was a most valuable asset in the planning and production stages of the New Mexico Conference. Each prospective Conference participant, including the participating representatives of the Coordinating Committee, was sent a copy of the report[5] of the national conference. Also a set of questions for pre-conference consideration was sent to each person as a method of introducing some of the problems and of promoting some independent thinking about the problems in advance. Due to the fact that only a two day conference could be scheduled, the Coordinating Committee found this orientation procedure to be of great value. The results were readily apparent in both the quality and quantity of work accomplished in that short time. These were the questions:

1. What background should teachers have in personal and community health?
2. Do we need a separate course in school health for teachers? Should elementary and secondary teachers have the same course or courses in school health?
3. Where does school health fit into:
   a. General curriculum courses
   b. General methods courses
   c. Child growth and development courses
   d. Educational psychology and guidance courses
   e. Laboratory experiences, including student teaching
4. How can the interdepartmental approach to preparation in school health be facilitated?
5. Who should teach school health and health education?
6. Should effort be made to secure a school health requirement for certification?
7. Should we consider the area of personal health status of prospective teachers as a part of our discussion?

Also, a pre-conference questionnaire was sent to each college and university in an attempt to determine the current status of their school health and health education programs for prospective teachers. The questionnaire had been carefully drafted, and went through several revisions before its distribution. However, this project turned out to be almost worthless. So much confusion existed within and among these various schools concerning school health semantics that most of the questions were misinterpreted. The answers were consequently of little value in gaining an accurate picture. An effort was made to forestall this dilemma by inserting some definitions of terms at the beginning of the questionnaire, but to little avail. Questions asked related to courses being offered or required in the areas of school health and personal and community health; the educational background of those teaching these courses; school health opportunities in student teaching pro-

5 National Conference on College Health Education, op. cit.

grams; campus health resources; health screening procedures for student teachers; existence of campus health councils; and the extent of contributions, in terms of personnel and facilities, by the various departments in the institution to the school health courses taken by prospective teachers.

One of the potential values of a conference is the opportunity to improve communication. In the New Mexico conference, this was evidenced by the fact that after the Conference the semantics problems were insignificant when subsequent questionnaires were sent to the same persons who received the pre-conference questionnaire.

The Coordinating Committee felt that one of the major factors contributing to the success of the Conference itself was the sequence of program content. For example, in our final afternoon session, a dean from each college and university reported to the entire group concerning his or her own institution's immediate plans for health program improvement. The results were amazing. The first report was exceptionally progressive and seemed to set a stimulating example for each of the remaining reports given.

Another major factor in the Conference's success was that each college and university dean, with one exception, as well as all the heads of departments of health, physical education and recreation participated. A successful effort was made to discuss all problems and recommendations *until unanimous agreement was reached on each decision.* The results were what the participants wanted, based on group discussions and decisions concerning realistic needs and problems. It far surpassed the results for which the Coordinating Committee had hoped. Conference followup activities indicated that the participation and contributions of these deans, particularly, were greatly instrumental in paving the way for rapid progress in carrying out recommendations made.

A Backward Look — In the process of evaluating what has been accomplished with this project over the past year, it became obvious that the methods and techniques used in planning and conducting the Conference produced more than the desired results in helping to make the Conference itself an apparent success. However, "the proof of the pudding is in the eating". The real success of the Conference could be measured only by the degree to which recommendations were carried out, and, ultimately, an actual improvement of health programs in the schools. In the Coordinating Committee's retrospective opinion, therefore, the followup

phase of the Conference has been perhaps the most important single phase of the project. The recommendations of many seemingly "successful" education conferences have been seen to be forgotten quickly or lost in the sea of other pressing education problems and endless pressures faced by college and university administrators, as a result of an inadequate follow-up program. Therefore, the Coordinating Committee made basic plans to keep in close contact with all Conference participants, making periodic surveys of progress, keeping them informed of every major development and accomplishment as they occurred, and involving them where possible in plans for the future.

The Future — Three years have now elapsed since the Coordinating Committee was formed and the seed planted. One factor in the progress of projects and programs stands out above the rest. The value of the coordinated team approach in working toward the solution of school health problems and establishing programs has proved itself in New Mexico. Many problems lie ahead. The dynamic, ever changing nature of school health programs assures a future filled with challenges. But with the kinds of cooperative efforts evidenced in past work, the membership of the Coordinating Committee looks forward with confidence to meeting these challenges.

* * * * *

P.T.A.'s NEW HEALTH PROGRAM

We have the child in school some forty hours per week for some thirty-six weeks of the year. For the other hundred and twenty-eight hours per week and the other sixteen weeks of the year he is mainly the creature of the home and community environment.

One of the leading organized groups to reach the child at the grass roots level in this environment is the P.T.A.

The National Congress of Parents and Teachers, during the past three years, has been revising its health program. It has taken formal action as follows:

(1) It adopted a policy supporting and encouraging a program of continuous health supervision of children from birth through their school experience, rather than only a program of single appraisal on school entrance.

(2) It decided to recommend to its local units a promotional and educational program that will tend to bring children and their parents into effective contact with the health resources of the community.

A more complete account of the program was reported in the November, 1956, *Journal of School Health.* School Health people would do well to contact their state and local P.T.A.'s and cooperate in developing this most worthwhile program.

A. O. DeWeese, *M.D.*

BROKEN HOMES: THEIR INFLUENCE ON CHILDREN

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Our school is situated in a large city of one of the greatest industrial areas of the United States. This accounts for the fact that many of our parents are employed in manufacturing plants or on construction projects. As a result about 20% of our school enrollment is very unstable, since at the end of a construction project families move to greener pastures and plant workers shift from one job to another.

This factor, in itself, causes a feeling of insecurity on the part of children. It is not possible for a child to find his place in a school community when he is shifted from one school to another, sometimes as many as four or five times a year. When one adds to this the instability caused from a broken home, it can readily be seen why we have many insecure, emotionally upset, antagonistic children, who often have little interest in their school work and who feel that they must lash out at someone or something in order to get even with a world that permits such an existence.

The following figures are the results of a survey made in our school:

Number of children enrolled in school	850
Number of homes broken by divorce	54
Number of children who have one parent dead	15
Number where one parent is not in home (separated but not divorced)	11
Number in Home for Boys	3
Total number from broken homes	83
Percent from broken homes	9.7%

(this is approximately 10% of the total enrollment)

Some of these 83 children, it is true, lead very normal, wholesome lives, contributing much to the fine school system of which they are a part. All too many of them, however, are like the ones mentioned below.

1. Susie, aged 8 and Jimmie, aged 7, live alone with their father in a trailer, their mother having died about three years ago. The father loves his children and is trying in every way possible to make a good home for them, but one can readily see that such a set-up is not a normal one. Little Susie is old for her years. She prepares most of the meals, takes care of their trailer home, and "mothers" small Jimmie who often seems to live in a dream world all his own. Recently, he had the measles, and since the father was unable to find a woman to care for him, Susie had to stay home from school, adding the duties of nurse to her already over-burdened young shoulders. Through it all, she is a cheerful, intelligent child, able to take in her stride her unchildlike obligations. We can but ask ourselves, however, if it is fair to demand so much of one so young.

Susie's and Jimmie's teachers have shown great interest in the children, giving them special help and attention. The school nurse has made several visits to the home in order to discuss with the father the children's health problems. We are trying to lead Jimmie to face reality, instead of living in a dream world, and to see that Susie gets an opportunity for child-like pursuits in school.

2. Then there are the three children whose mother has left her husband, an alcoholic, in another state and has come with them to make her home with her sister's family of five who live in a two-room apartment. Inadequate food, clothing, and living conditions have made pitiful objects of these small children. Is it possible for them to come to school with minds receptive for learning?

   We cannot let these children reap the harvest their parents have sown; yet we do not wish them to become drains upon society. We are trying to teach them that they have certain responsibilities to their fellows, that they are to put forth some effort if they wish to receive. For their physical and emotional well being we have given them clothing, milk, and affection, trying to counterbalance in every way possible the bleakness of their home environment. The school nurse has discussed nutrition, sleep, and health habits with their mother.

3. Mary and Gary live with their mother and stepfather in an average middle class home. Mary is a quiet, happy little girl who does very satisfactory work in school and is liked by the other second grade children in her room. Quite different is her brother. He fights other children, uses bad language, and is indolent and disturbing in the room. Home contacts disclose that the stepfather is fond of Mary, giving her attention and companionship, but shows no affection for Gary. For the slightest misdemeanor the boy is severely punished and is made to feel unwanted by the father. As a result, Gary fights back when he is away from home.

   Little by little, under the guidance of an understanding teacher, Gary is beginning to feel that someone loves him too. There are still times when he "shows off" in order to gain attention, but we hope he will eventually learn that he can gain that attention by other means. We have also had Gary's own father in for a conference and suggested that he try to build up the boy's self-confidence on the weekends they spend together.

4. Charles comes from a very poor environment where there is no mother in the home. An older brother, who has been in trouble with the juvenile authorities, and a father who does "shift work," share the home with Charles. The father's work prevents him from being at home much at the times when he should be supervising the activities of his sons. Complaints from parents who have daughters in Charles' room bring to light the fact that the boy has been using unclean language in his conversation with the girls and has been passing around obscene literature. He usually has a dirty, unkempt appearance, a fact that is very understandable when one sees the home in which he lives.

   We are trying to show Charles another kind of life, a life where beauty and cleanliness of body and mind can be found. His teacher is a fine young man who is a gentleman at all times and always immaculately clean. He is serving as a very good example for Charles. Altho the boy is reading far below grade level, interesting stories of action have been given him in the hope that they would take the place of the obscene literature. The father was asked to come to the school for a conference, and a suggestion was made that he find time to be with his son and to see that regular bedtime hours for a sixth grader be adhered to.

5. And then there is Steven, a small, immature, smiling, lovable, but oh, so trying 8 year old. Things have such a way of disappearing when

Steven is around — everything from cookies to the new magnifying glass from the science table. He will tell one fantastic story after the other as to where he obtained the contraband articles, varying each time he retells the same story. When he finally realizes that his tales are not believed, and the Principal's hand is placed on the telephone to call his parents, he bursts into loud cries and pleas of, "Please, please don't call my mother. She will tell my father and he will whip me with the rubber hose." That this kind of punishment is frequently meted out to him we know, for he has come to school with red welts on his body. Steven is given very little love from either his father or his step-mother. He is always hungry — both for food and affection.

We try to give him these, altho he tries one's patience to the breaking point. Whenever it is possible to give praise, we give it eagerly. Steadily we work, trying to lead him to respect the property rights of others. "What's mine is mine; what's yours is yours" still seems to have little meaning for Steven, but we still hope for favorable results. The sad thing is that we get very little cooperation from the boy's parents.

And so it goes. We have found that in many instances the children from these broken homes are insecure, nervous, and easily disturbed. They have difficulties with other children on the playground, and do not do their best work in the class room. Many of them crave affection and attention. It takes a wise, understanding teacher — which fortunately we have in most cases — to combat these inside and outside influences and pressures that beset such children.

From school records, it may be an easy matter to tabulate or list the number of children who come from broken homes. It may be somewhat of a shock to realize this number is almost 10% of the total enrollment in a school — an average school such as may be found almost anywhere in the U.S.A.

The ways in which we try to deal with the personalities and educational problems of these boys and girls are so intangible that it is hard to set them down. We try to help them build attitudes; we attempt to help the child formulate a philosophy of life that will provide a foundation upon which to erect a future well being. Each child presents an individual problem and must be treated individually. The critics who have so lavishly found fault with our educational system in the United States might well take into consideration the handicaps under which we work and the backgrounds of some of our children. Is society doing its part to give us mentally, emotionally, and physically healthy children to educate? That is a question which we might well consider.

NEWS AND NOTES

Continuing Importance of TB

The present status of tuberculosis control in this country would lead one to think that the control of TB may require a long time. The case rates of tuberculosis have failed to decline as rapidly as the death rates. It is currently estimated that there are about a quarter of a million active cases of tuberculosis in the United States, of which 100,000 are unknown to health officials and probably are not under medical supervision.

While there are fewer patients under treatment in tuberculosis hospitals, there are increasing numbers being treated as "out patients." Unfortunately some of the latter group are not receiving adequate medical supervision.

TB and Other Respiratory Diseases Related

The relationship between tuberculosis and other respiratory diseases is so intimate, particularly from the medical standpoint, that from the very beginning it has been impossible to be concerned only with tuberculosis and not with other respiratory diseases. Thus, silicosis, which notoriously plays an important role in precipitating the development of active tuberculosis disease, has been a concern of the NTA and its affiliates from the time of the founding of the NTA more than half a century ago. At the present time, through improved bacteriological methods, more and more illnesses clinically indistinguishable from tuberculosis are being recognized which are found to be due to mycobacteria similar to, but distinct from the *Mycobacterium tuberculosis*. There is an intimate relationship between tuberculosis and emphysema and chronic bronchitis, and outbreaks of influenza notoriously have been accompanied by a spiking of the tuberculosis death rate.

Respiratory diseases as a whole form a group of illnesses of tremendous public health importance which have been badly neglected in the past, and which the NTA, together with its medical section, the American Trudeau Society, and the affiliated tuberculosis associations, can be helpful in studying and bringing under better control. Based on a three-year average of deaths in 1953-55, these diseases as a group (excluding cancer of the respiratory system) are fifth in the list of causes of death, being exceeded only by heart disease, cancer, vascular lesions affecting the central nervous system, and accidents. If cancer of the respiratory system is added to the group, it becomes the number four cause of death.

So far as frequency of illness is concerned, rather than mortality, there is no question but that respiratory illnesses head the list.

General Practitioners Important

Why should this extension of interest be mentioned in an *Abstract* intended primarily for the general practitioner? The reason is that the general practitioner is the key person in the control of all of these respiratory diseases, including tuberculosis. As far as tuberculosis itself is concerned, with the development in recent years of effective drugs in the treatment of tuberculosis, the general practitioner has become even more important than he was before. He always has been a most fruitful source of finding cases of tuberculosis. The degree to which he keeps tuberculosis in mind as a possible cause of the symptoms which he notes in patients consulting him determines to a large extent how quickly tuberculosis is diagnosed, how soon the patient is put under adequate treatment, the patient's chances for recovery with a minimum of permanent disability, and the likelihood of spread of the disease to others.

Now that patients are discharged earlier from hospitals than before and at a time they must continue their therapy for many months after discharge, the general practitioner is a key man in determining the ultimate status of the patient. If he fails to keep the patient under adequate supervision and therapy for a sufficiently prolonged period of time, relapse is almost inevitable, resulting in an individual who is more likely to have a permanent disability if not an early death, and with the likelihood of further spread of the disease to his associates.

With regard to other chronic respiratory conditions, the practicing physician, again, is the key person with regard to detecting these in their early stages and putting the patient under adequate supervision and therapy to prevent the patient from becoming a chronic respiratory cripple. He is the key man in deciding whether or not the citizens in his community are adequately immunized against those respiratory diseases for which vaccines are available (or in which the respiratory system may be involved in transmission), such as diphtheria, whooping cough, smallpox, poliomyelitis, and influenza.

TB Still Primary Interest of TB Associations

The National Tuberculosis Association, its medical section, the American Trudeau Society, the state tuberculosis association and Trudeau societies and the local associations will continue to devote their primary attention to the tuberculosis problem. They are also interested in trying to help in the solution of the other important respiratory illnesses plaguing mankind. They will promote good health in your community in close cooperation with the medical and nursing professions and public health officials. Through research, through community service, through education—new ways for attacking the broad problems of respiratory disease will be found.

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